POC accepted/approved 9-12-16

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 08/16/2016
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	445159	A. BUILDING ______ B. WING ______	08/11/2016

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BETHANY HEALTH CARE CENTER	421 OCALA DRIVE NASHVILLE, TN 37211

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F 000	INITIAL COMMENTS A Comparative Federal Monitoring Survey was conducted at Bethany Health Care Center on August 8-11, 2016. The facility was found not in substantial compliance with Medicare regulations at 42CFR 483, Subpart-B, Requirements for Long Term Care Facilities. The following deficiencies resulted from the facilitys non-compliance. The census was 134.	F 000	Correction was made to the nurse staffing information by removing the projected 3-11 and 11-7 shift hours from the form. The form was then immediately reposted by LPN #1 and the First Floor Unit Clerk on 8/11/16.	8/31/16
F 356 SS=C	483.30(e) POSTED NURSE STAFFING INFORMATION The facility must post the following information on a daily basis: o Facility name. o The current date. o The total number and the actual hours worked by the following categories of licensed and unlicensed nursing staff directly responsible for resident care per shift: - Registered nurses. - Licensed practical nurses or licensed vocational nurses (as defined under State law). - Certified nurse aides. o Resident census. The facility must post the nurse staffing data specified above on a daily basis at the beginning of each shift. Data must be posted as follows: o Clear and readable format. o In a prominent place readily accessible to residents and visitors. The facility must, upon oral or written request, make nurse staffing data available to the public for review at a cost not to exceed the community standard.	F 356	The Administrator immediately notified the maintenance department to lower the bulletin board used for posting the staffing information on 8/11/16. The maintenance staff lowered the bulletin board to a height visible by those seated in a wheelchair on 8/11/16. The visibility was confirmed by the Administrator. (See Attachment #1) There are no other areas in the building with posted staffing information. The procedure for posting staffing information was revised by the DON and approved by the Administrator on 8/22/16. (See Attachment #2)	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
[signature]	NHA	8/26/16

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 356	Continued From page 1 The facility must maintain the posted daily nurse staffing data for a minimum of 18 months, or as required by State law, whichever is greater. This REQUIREMENT is not met as evidenced by: Based on observations, record review and staff interviews, the facility failed to post nurse staffing at the beginning of each shift and in a manner that was accessible to wheelchair bound residents for four (4) of four(4) days. The findings include: During the initial tour of the facility on 8/8/16 at 2:08 p.m., the nurse staffing information was observed on the wall beside the first floor elevator and was posted at eye level. The staffing was posted for first, second and third shifts, but did not include the total number of hours. On 8/9/16 at 9:56 a.m., 8/10/16 at 8:51 a.m., and 8/11/16 at 7:59 a.m., the nurse staffing was posted prior the start of second and third shifts. During an interview conducted on 8/11/16 at 11:28 a.m., with Licensed Practical Nurse (LPN) #1 and the Unit Clerk for the first floor, both confirmed the nurse staffing was posted in advance for second and third shifts, and was out of reach for wheelchair bound residents. Both staff members acknowledged they were responsible for posting the staffing in addition to various LPNs and Certified Nurse Technicians. In an interview conducted on 8/11/16 at 11:44 a.m., the administrator confirmed she expected the nurse staffing to be posted in accordance with the regulatory requirement.	F 356	Staff in-services were initiated regarding the revised procedure beginning 8/23/16 with the DON, Unit Managers, Nursing Supervisors, Unit Clerks and Business Office staff members. In-services are to be completed August 29, 2016. (See Attachment #3) The DON and Unit Managers will monitor the accuracy and timing of posted staffing information for compliance with the revised procedure. The audits will be conducted after the beginning of the shift at least three times per week per shift. Audits began 8/15/16. Any identified problems will be addressed immediately with the staff member who posted the information. The result of monitoring for compliance with posted staffing information will be reported to the DON. The DON will compile the results into a report that is provided to the Administrator and the QAPI Committee on a monthly basis. Reporting will continue monthly for at least six months.	

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F 356	Continued From page 2	F 356	After six months, the frequency of reporting will be determined by the QAPI Committee. The first report will be provided to the QAPI Committee at the August 29, 2016 meeting. The QAPI Committee meets monthly with membership including the Medical Director, Administrator, DON, First and Second Floor Unit Managers, MDS Staff Members, Activities Director, Dietary Manager, Environmental Services Director, Clinical Coordinator/ Infection Control Coordinator, Social Services Director, Personnel Director and the Admissions Director.	

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F 441 SS=E	483.65 INFECTION CONTROL, PREVENT SPREAD, LINENS The facility must establish and maintain an infection Control Program designed to provide a safe, sanitary and comfortable environment and to help prevent the development and transmission of disease and infection. (a) Infection Control Program The facility must establish an Infection Control Program under which it - (1) Investigates, controls, and prevents infections in the facility; (2) Decides what procedures, such as isolation, should be applied to an individual resident; and (3) Maintains a record of incidents and corrective actions related to infections. (b) Preventing Spread of Infection (1) When the Infection Control Program determines that a resident needs isolation to prevent the spread of infection, the facility must isolate the resident. (2) The facility must prohibit employees with a communicable disease or infected skin lesions from direct contact with residents or their food, if direct contact will transmit the disease. (3) The facility must require staff to wash their hands after each direct resident contact for which hand washing is indicated by accepted professional practice. (c) Linens Personnel must handle, store, process and transport linens so as to prevent the spread of infection.	F 441	CNT #1 was given in-service education by the 2nd Floor Unit Manager regarding Infection Control procedures when providing incontinence care including use of gloves, handwashing and prevention of cross contamination. The in-service was provided on 8/9/16. (See Attachment #4). Following the in- service, the CNT was able to verbalize the correct procedure for infection control. After the in-service, a follow up observation of CNT #1 was made by the 2nd Floor Unit Manager to ensure CNT #1 followed the correct procedure for infection Control during incontinence care. The observation was completed 8/9/16. The CNT followed the appropriate infection control procedure. Housekeeping staff disinfected the furniture and surfaces in the room of Resident #272 on 8/9/16.	9/2/16

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F 441	Continued From page 3 This REQUIREMENT is not met as evidenced by: Based on observations, record reviews, staff interviews, and review of facility policy entitled "Isolation," the facility failed to ensure staff followed infection control practices as outlined in their program in regards to changing gloves and washing hands for one (1) of one (1) resident observed for incontinence care (Resident #272), and donning/doffing Personal Protective Equipment (PPE) while delivering lunch trays for two (2) of three (3) residents on contact isolation (Resident #'s 272 and 283). The findings include: 1) Resident #272 was admitted to the facility on 7/11/16, with diagnoses that included Sepsis due to Escherichia Coli and Enterocolitis due to Clostridium Difficile (C Diff). On 7/13/16, the physician wrote an order for "Strict Isolation-Digestive. Type of Isolation: contact for C-Diff." The order was discontinued on 7/15/16 but reordered on 7/31/16 and remained in effect. On 8/9/16 from 10:45 a.m. until 11:11 a.m., Certified Nurse Technician (CNT) #1 was observed providing incontinence care to Resident #272. CNT #1 donned gloves and gown, and obtained towels, washcloths and plastic bags before entering the room. During the care, CNT #1 instructed the resident to turn on her right side. The CNT removed the resident's brief (which was soiled with feces) and placed the brief in a trashcan on the floor. She performed incontinence care to the resident's rectum and buttocks and without changing gloves, touched a clean pad and started to place the pad under the resident. The CNT decided the pad that was	F 441	On 8/9/16 and 8/10/16, In-service education was provided for other staff members on duty regarding Infection Control procedures including use of gloves, hand hygiene and prevention of cross contamination. (See Attachment #5) The First and Second Floor Unit Managers and Nursing Supervisors initiated observations of CNT staff members performing incontinence care to ensure compliance with infection control procedures. Observations were initiated 8/9/16. On 8/9/16, CNTs #2, #3 and #4 were immediately provided in-service regarding Isolation Procedures and required personal protective equipment. (See Attachment #6).	

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F 441	Continued From page 4 originally under the resident wasn't soiled and removed the clean pad. She had the resident turn on her back and with the same gloves, performed incontinence care to the groin area. The CNT then went to the bathroom, changed gloves and got more linen. She did not wash her hands between glove change. She returned to the resident and instructed the resident turn to her left side. The CNT continued with incontinence care to the buttocks, removed the soiled folded sheet and noted the pad that was under the resident was soiled. She did not change gloves but grabbed the pad that she had contaminated earlier and placed it under the resident. She did not change or remove her gloves, but obtained a brief from a drawer in the resident's room and placed on the resident. She tied both bags (linen and trash), removed her gloves and gown and without washing her hands, left the room with the bags. On 8/09/16 at 11:31 a.m., an interview was conducted with CNT #1. The CNT stated "I should have changed my gloves three (3) times." She confirmed that she left the room to take the bags to the soiled utility room without washing her hands. She also confirmed that she should have changed gloves before touching the clean pad and brief. On 8/11/16 at 11:01 a.m., an interview was conducted with the Clinical Coordinator/Wound Care Director (that also oversaw the infection control program). She stated that she would expect the staff not to cross contaminate during care of the resident. "They (staff) needed to be washing hands between clean and dirty. She definitely needed to wash her hands before leaving the room."	F 441	In-service education regarding Isolation Procedures was provided for other staff on duty on 8/9/16 and 8/10/16. (See Attachment #5) Observations for compliance with Isolation procedures were initiated by the Unit Managers, Nursing Supervisors and Infection Control Nurse on 8/9/16 and continued through 8/10/16. Additional Infection Control in-service education covering Isolation procedures, use of personal protective equipment, hand hygiene, and prevention of cross contamination was provided for all facility staff members. In-services to be completed by 9/1/16. (See Attachment #7). Staff members who did not work during this time period will be educated on their next scheduled work day.	

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F 441	Continued From page 5 On 8/9/16 at 12:53 p.m., CNT #2 asked CNT #3 if she needed to put a gown and gloves on before entering Resident #272's room to deliver her lunch tray. CNT #3 told CNT #2 that she did not. CNT #2 entered the room, delivered the tray, touched the over bed table to move it closer to the resident, then exited the room without washing her hands. She went to the restroom that was located across from the nurse's station, touched the door knob (it was locked), then went to the staff lounge and washed her hands. 2) Resident #283 was admitted to the facility on 8/5/16 with diagnoses that included Methicillin Resistant Staphylococcus Aureus (MRSA) in the wound. On 8/8/16, the physician wrote orders for "Strict Isolation-Skin. Type of Isolation: Contact. Reason for Isolation: MRSA." On 8/9/16 at 12:49 p.m., CNT #4 was observed entering the resident's room, and delivered Resident #283's lunch tray without donning a gown or gloves. 8/11/16 11:01 a.m., an interview was conducted with the Clinical Coordinator and Wound Care Director (she also oversaw the infection control program). She stated she expected the staff to wear gloves and gowns, "when they enter the room for any reason as indicated on the cards on their doors." Review of the facility's policy entitled "Isolation" with an effective date of May 1, 2008, listed under Contact Precautions: "c. Gloves and Handwashing - 1) In addition to wearing gloves as outlined under Standard Precautions, wear gloves (clean, non-sterile)	F 441	Monitoring for compliance with Infection Control procedures has been initiated. Observations will be made by the First and Second Floor Unit Managers, Nurse Supervisors, Infection Control Coordinator and the DON. At least 5 observations per shift per week will be made of staff entering/exiting any existing Isolation Rooms and at least 5 observations of staff members while providing incontinence care. Observations began August 21, 2016. Any staff member(s) observed with deficient practice will be educated immediately, the appropriate corrective action will be initiated as indicated and a follow-up observation will be made to ensure compliance.	

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F 441	Continued From page 6 when entering the room. 2) While caring for a resident, change gloves after having contact with infective material (for example, fecal material and wound drainage). 3) Remove gloves before leaving the room and wash hands immediately with an antimicrobial agent or a waterless antiseptic agent. d. Gown - 1) In addition to wearing a gown as outlined under Standard Precautions, wear a gown (clean, non-sterile) for all interactions that may involve contact with the resident or potentially contaminated items in the resident's environment."	F 441	The observation findings will be reported to the DON. The DON will compile a monthly report and provide to the Administrator and to the QAPI Committee, beginning with the next scheduled meeting of August 29, 2016. The report will include the total number of staff members observed, any deficient practice identified, corrective action initiated and follow-up observations as indicated. Monitoring will continue for at least 3 months. After 3 months, the QAPI Committee will determine the frequency of monitoring and reporting thereafter.	

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F 441	Continued From page 7	F 441	The QAPI Committee meets monthly with membership including the Medical Director, Administrator, DON, First and Second Floor Unit Managers, MDS Staff Members, Activities Director, Dietary Manager, Environmental Services Director, Clinical Coordinator/ Infection Control Coordinator, Social Services Director, Personnel Director and the Admissions Director.	